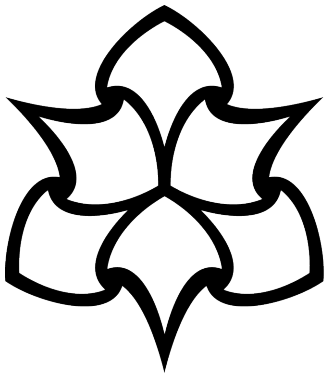

Reflections on being an oral history insider: subjectivity, intersubjectivity and speech therapy

by Jois Stansfield

Abstract: Speech therapy in the UK is a relatively small profession with a unified professional body being established in 1945. The first members of this body had careers influenced by major social environmental and social policy changes in the second half of the twentieth century, but their voices have largely been unheard. This article is based on an oral history study carried out with speech therapists who qualified after the Second World War. It explores the opportunities and challenges involved in being a speech therapy insider collecting these oral histories. It argues that, despite, or possibly because of, my constant self-questioning throughout the process, my insider status was more of a benefit than a disadvantage in constructing the resulting oral history.

Keywords: speech therapy; professional history; insider interviewing; intersubjectivity; women's careers

Reflecting on her career in speech therapy over four decades, Janet (class of 1959) said:

> A great learning profession, speech and language therapy. Every day there was something new […] if you really want to do it, it's the best job in the world. It's very, very satisfying'.[1]

Speech therapy is a relatively small profession, which has grown from fewer than 200 people, almost all women, in the immediate years after the Second World War, to around 17,000 today, of whom fewer than four per cent are men.[2] Speaking to speech therapists informally, the majority, like Janet above, report enjoyment of their careers. However, while there is some limited information about speech therapy's history, there is little written that reflects the experiences of the therapists themselves. This paper explores the opportunities and challenges involved in collecting oral histories as an insider, reflecting on the impact of subjectivity and intersubjectivity on the outcomes of interviews conducted with speech therapists who qualified after the Second World War. It argues that, despite, or possibly because of, constant self-questioning throughout the process, my insider status was more of a benefit than a disadvantage in constructing the resulting oral history.

Speech therapists work with people of all ages who have difficulties in communicating, as a result, for example, of a stammer, a stroke or indeed a voice disorder. Oral historians aim to enable the voices of those rarely heard to contribute to our understanding of the world. As such, oral history shares with speech therapy a focus on communication in its broadest sense, not just listening but also observing the ways in which people speak and act in expressing their beliefs, feelings and motivations. The aim of this study was to complement and enrich the existing, very limited evidence base on the profession's history in collaboration with the people at the heart of the experience. Oral history was the method of choice for this study, explicitly because to date there has been no attempt to employ this methodology to gain information about the experiences of speech therapists. The paper draws on the available literature to present a brief historiography of speech therapy, outlining the

written record, before considering the impact of subjectivity and intersubjectivity on the process and outcome of this oral history study.

Background history

Speech therapy emerged in the late eighteenth and nineteenth centuries, adopting a service rather than a business model in the twentieth century. While there is very little historiographical material about speech therapy in the UK prior to the twentieth century, reports from the time indicate that it was carried out predominantly by individuals interested in a combination of public speaking, rhetoric, elocution and correcting 'speech defects'.[3] These were usually men, supported by their sons and occasionally wives and daughters, who built businesses around their various speech work.[4] Stammering aroused the attention of surgeons as well as elocutionists; the 'deaf and dumb' attracted interest from educationalists; neurologists studying the results of stroke began identifying areas of the brain involved in speech production; and the physician John Wyllie wrote, lectured on and treated speech disorders. Thus, by the end of the nineteenth century there was a body of knowledge and a small number of practitioners who were involved in the study and remediation of disorders of speech.[5]

There is a little more literature available regarding the twentieth century, although here too historiography is sparse. Judy Duchan hosts a website on the history of speech-language pathology, especially of the US speech pathology profession before 2000.[6] Margaret Eldridge gives an overview of speech therapy internationally, considering parallel developments in the UK, eastern and western Europe and the US from 1900 to the mid-1960s.[7] She suggests that the profession moved from trial and error in the early twentieth century, to increasing professionalism in the 1930s, becoming part of wider established systems during and after the Second World War. What is striking from both Eldridge's and Duchan's work is the similarity in direction across almost all the countries considered (despite the interruptions of war), with the profession drawing increasingly upon the expertise of medics, educationalists, psychologists and phoneticians to increase understanding of the nature and treatment of speech disorders.

Gradually over the first half of the twentieth century, 'speech classes' and lectures on speech disorders emerged.[8] Glasgow and Manchester began to provide classes for stammerers in 1906, while in 1918 London County Council (LCC) also opened four school clinics for children who stammered.[9] Concurrently, speech therapy clinics were established in three London hospitals to provide therapy for adults.[10] At that point, speech therapists had varying training. Most trained themselves, using their existing professional backgrounds and experience as a starting point. Elocutionists, teachers of the deaf, speech teachers with remedial experience and phoneticians all entered the field.[11]

Primary source material indicates that the profession also became increasingly feminised. The First World War decimated the male population and between the wars around twenty percent of women 'of marriageable age' remained single.[12] It is likely that this stimulated their need to find an outlet for their energies and certainly many speech therapists who emerged after 1918 remained single. Examples are Winifred Kingdon-Ward (1884-1979) and Anne McAllister (1892-1983). Typical of

speech therapists of the time, both were upper-middle-class women. Kingdon-Ward studied singing and speech, and worked with injured servicemen during the First World War, subsequently establishing two schools of speech therapy in London.[13] McAllister mirrored this experience in Glasgow. A Scot whose academic work as a phonetician in Glasgow led her to speech therapy, 'Dr Anne' as she became known, first started teaching about speech disorders in 1919, and established the Glasgow School of Speech Therapy in 1935.[14]

[Insert images 1 and 3 around here]

Formal training thus began to develop in London and Glasgow in the 1920s and by the 1930s there were four schools in London and one in Glasgow, offering two-year (or in one case three-year) qualifications. The profession had also started to organise, and two competing professional organisations emerged: the Association of Teachers of Speech and Drama (Remedial Section) (AST) in 1934, and the Society of Speech Therapists (SST) in 1935, which allied itself with the medical profession. By the mid-twentieth century, as a result of outside pressure, these two organisations amalgamated, establishing a single professional body and voice, with the professional body, the College of Speech Therapists (CST), being formally inaugurated in 1945.[15] The register of 1946 indicated a total of 199 practising speech therapists, of whom only eight were men, with a further twenty-four women registered as 'non-practising'.[16] Seven more (all women) were listed as being on active service, one of whom, it has subsequently emerged, was engaged in work at Bletchley Park.[17]

[Insert images 4-6 around here]

Although the information is sparse, from the available publications it can be seen that speech therapy followed a similar path to other emerging health professions: personal interest in helping those with impairments; academic development through self-study; formal training; establishment of professional bodies; and feminisation.[18]

Uncovering personal stories

How then do we find out about the personal experiences of individuals engaging in speech therapy practice? Autobiographies can give individual pictures and four books have described the state of speech therapy between the early 1920s and the 2000s.[19] Joyce Wilkins outlined a bespoke course, which is the closest we come to seeing first-hand how speech therapists were educated at the beginning of the 1920s. Catherine Hollingworth straddled the divides between children's theatre and speech therapy, doing on-the-job speech therapy training in the 1930s. Betty Byers Brown, an eminent academic in the profession, established the University of Manchester's speech therapy degree course in 1974 and became the first advisor on speech therapy to the UK Department of Health. Eleanor Hewerdine (better known at the time as Eleanor Gildea) worked in Northern Ireland, becoming a speech therapy manager in the 1980s. All these autobiographies are valuable as personal records. Short career outlines can also sometimes be found as brief articles in the *Bulletin: The official magazine of the Royal College of Speech and Language Therapists*. These outlines and autobiographies are, however, few and far between.

The first members of the unified profession are growing older and now well into retirement. Their careers were influenced by major social and social policy changes in the second half of the twentieth century, but their voices have largely been unheard. There is a risk that their experiences will be lost unless they are recorded. Oral history offers the opportunity to hear personal stories and collaborate in developing a narrative. Shopes writes of oral history as being a process requiring sensitivity in interviewing, tenacity in transcription, rigour, but also humility and reflexivity in interpretation, in order to construct a story that is truthful to the narrator while giving a theoretically grounded product which adds historical value.[20] A major benefit is that it allows a different perspective on history, opening windows onto alternative worldviews from those found in the written word.[21]

> *Meg (class of 1950):* I didn't want to do speech therapy […] I really wanted to go on the stage […] the college in [city] was linked to the drama school and I thought there might be some way of transferring or soaking up something.

As the quote above from one participant who had a lifelong career in the profession suggests, things are not always as they first appear. Oral history facilitates a more nuanced understanding of people's experiences. It can also encourage those who do not claim eminence – such as Susan (class of 1955), 'I don't see myself as having an impact on [the profession]' – to have their voices heard, allowing their story, co-constructed between the participant and researcher, to be shared.

Subjectivity and intersubjectivity

Abrams is clear that in oral history, narrators and researchers have numerous identities and these colour the self, constructed in relation to social and cultural environments: only part of these is revealed in any given situation.[22] The narrator will have a subjective identity with regard, for example, to gender, class, privilege, age and facility with language, and this self will have its own construction, specific to the interview situation, that they are willing to reveal to the researcher. The researcher will also have a personal subjectivity. Within the research context they may be an insider or outsider, and while such overt things as their age, gender, ethnicity, use of language and paralinguistic communication including accent, can influence the interview positively or negatively, their internal values base, level of confidence and mood can also affect the interaction. These subjectivities are referred to by Abrams as emotional baggage. However, they are more than emotional and more than baggage, forming a deep-seated core of a person's identity, only some of which will be revealed explicitly within the interview. Each of these subjectivities will reflect a continuity of internal and external self-representation over time and, to a lesser or greater extent, a meta-self, that is, reflexivity on the version of the self being presented. These then combine to influence intersubjective communication during oral history interviews.[23]

For the purposes of this study I was an insider. My personal background is as a speech and language therapist (SLT), recently semi-retired, with a long-term interest in professional history. I am confident in my professional identity as an SLT, with experience of clinical and research interviewing, and knowledge of and contributions to RCSLT policy development, but my self-identity as an historian has developed only slowly. Interest is a necessary, but not sufficient, basis for constructing a

trustworthy oral history, and a theoretical grounding is also essential. I have been lucky to achieve this through recent MSc study, of which the oral history presented here forms a part.

There are arguments for and against being an insider collecting oral histories. Yow suggests that being an insider may increase the trust felt by narrators. However, there is a danger that shared knowledge may leave areas of interest unspoken or unexplored. Equally, an insider may assume knowledge of a shared culture which is different from the actual experience of the narrator, something that requires careful listening to overcome.[24]

A specific consideration for this study was that for speech and language therapy communication (verbal and non-verbal) is the medium of practice as well as the mode of data collection in oral history. As an SLT insider, co-construction of a coherent story with participants, who themselves were well grounded in theories of communication and communication disorder, had the potential to lead to some exchanges that reflected the professional debates around communication itself. Some of this was evident in the conversational exchanges: talking about talk (metalinguistics), in-jokes or the word play of the profession may have rendered the resulting exchanges inaccessible to outsiders.

Insider issues, especially those involving subjectivity and intersubjectivity, unsurprisingly arose at every point of this study. Decisions needed to be made before the project started and during the process. Reflecting on these issues drew my attention to a range of considerations I needed to take into account from instigation to completion, and demonstrated the complexity of the decisions required throughout both the process and the product resulting from it. These spanned inclusion criteria, recruitment, ethical issues and interviewing, analysis and reporting.

Participants

The first decision was who to record. I wanted to distance myself from the generation I was to interview and took an upper cut-off point clearly earlier than my own qualification date, so that I did not end up interviewing people with whom I may have worked. The inclusion criterion was therefore any speech therapist who had qualified between 1945 and 1970, thus having had the opportunity for a full career.

Some insider challenges are subtle. For me, there was a concern to maintain a positive reputation in a small profession, and a tension between recruiting the most vocal, the most representative and the most interesting voices. As such, initial questions were who would be the best participants to tell their stories and how to recruit people legitimately while avoiding bias. There are some well-known names within the speech therapy field and their views can be found in their contributions to the profession's literature as well as the Royal College of Speech and Language Therapists' (RCSLT) archive material (committee minutes for example). I did not want to exclude this elite: charismatic, opinionated women who had steered the profession forward through their professional body leadership, academic publications and campaigns for the profession to gain enhanced visibility. However, I intended that the recruitment process would also include individuals who reflected more typical working experiences of speech therapists over the period, thus giving a more

inclusive view of professional lives. It took time to work out how to go about this. A direct approach to older therapists might make them feel coerced into contributing, while asking only those with whom I felt affinity might raise the charge of partiality. I did take what was probably a cowardly decision on one point. Several of the eventual participants mentioned one individual I could interview and I knew she would have a wealth of information to share. I had always had a distant and difficult relationship with her, however, and in this case took the decision that my own self-protection was more important than the inevitable confrontation I believed would result, so decided against approaching her.

> *Susan:* Your time would not be wasted.
> *Interviewer:* I know the time wouldn't be wasted, but it's whether I'm shredded at the same time.

Using historical professional body databases (the last publicly available *RCSLT Register*, with names, addresses and phone numbers was issued in 2004) risked approaching people who were no longer interested in the profession or who may have passed away, potentially creating distress for remaining family members. In the end, professional networks were used indirectly. Invitation letters and an outline of the project were circulated by a gatekeeper (a recently retired colleague) to a retired therapists' network in Scotland. Concurrently the membership officer of RCSLT agreed to circulate the same documentation to a sample of individuals across the UK who fulfilled the inclusion criteria and still held College membership. Each of these approaches made it clear that I did not know who received the information and that I would be in touch only if someone contacted me to express an interest. From these approaches, a total of twenty people, all women, volunteered, some of whom I had known personally, some by reputation and some not at all until we met. Two qualified in the 1940s, twelve in the 1950s and six in the 1960s.

Preparation

The next decision was how to record. It is possible to collect written narratives by email, which saves time in transcribing, but not everyone (especially older people) has an email address and the individual written word lacks the richness of a co-constructed story collected through interview interaction. In addition, as noted above, there are already some written memoirs, but these are marginal to the concept of oral history.[25] I considered video, but this needs a competent interviewer to set up the recording, something I did not feel confident to do: at least one participant expressed relief she would not be on film. Audio-recorded interviews lose facial expressions, but are quick and easy to organise and with the current size of recording equipment less intrusive than video recording, so this was the medium of choice.

Focus groups could be audio recorded and these are valuable for many purposes, but the aim was to recruit across the UK and travel to a central venue may not have been possible for some participants. Focus groups in any event do not elicit individual experiences uninfluenced by the views of others. On a practical level, as an insider knowing the profession, I felt that the more opinionated voices may have drowned out other equally credible stories. As a result, I decided to audio record individual interviews, using an Olympus digital voice-recorder VIN-731PC, and the

MP4 recording facility on a mobile phone, thus having two sources as advised by Clarke and Braun.[26] This turned out to be a necessary precaution, as user error (my incompetence) meant that on four occasions only one of the recorders took in the full interview. I also made written field notes, again useful as one recording was very difficult to hear but possible to interpret from the supporting written record.

Thompson suggests that it is necessary to have some knowledge of a topic in order to elicit valuable historical narratives.[27] In this respect, I felt reasonably well informed. I have a good working knowledge of speech therapy history and have access to the RCSLT archive through my membership of the professional body. Lummis makes the point that the researcher also needs some idea of what they want to know and how evidence can be collected in a historically useful manner.[28] Again, this was something I had prepared for, with consideration of the areas I hoped to explore. All the participants received a topic guide prior to contacting me.

My own subjectivity influenced my approach to the interviews. I wanted to demonstrate respect for the participants so I thought about my appearance and dressed professionally. I ensured I was on time and for each person I took flowers or offered a small gift as thanks for participating.

Ethical issues

As a speech and language therapist, my previous research has been embedded in health-service mores, with the default setting of confidentiality and anonymity being core to my thinking. While I understood in theory that some participants would wish for their names, voices and transcripts to be freely accessible, I found this a real challenge to accept in practice. Could they really mean it? Did they understand the ubiquitous and long lifespan of social media and how things could be manipulated? Was their consent in line with the General Data Protection Regulations (GDPR) which came into being during the study?[29] My overprotectiveness could be seen as paternalism, or maybe maternalism, and I had to revise my attitude, not least as most participants made it clear that they were happy for everything they said, along with their name, to be in the public domain, although this remains an area where I feel less than comfortable. Indeed in presentations to date (and in this paper) I have used pseudonyms, although all the recordings and transcripts have been treated in accordance with the participants' wishes.

A further decision was whether or not participants should have the opportunity to check transcripts. Participant checking has been my practice in previous research, although I have found, especially with speech and language therapists, that there is the risk that they edit and change the text, which then raises the question of what counts as data: the audio recording, the original transcript or an amended transcript? In fact, the range of responses surprised me. One individual withdrew completely, which of course was her prerogative, but disappointing as I had thought this to be a positive interview with valuable insights into the profession. Three requested that the material was not archived, but gave continued permission to use the transcript data. Another edited the transcript to form a rather more coherent narrative and removed a very funny but scurrilous anecdote, while some corrected minor errors in spelling, place and person names. The others made no changes, appearing satisfied with the transcriptions.

The interviews

Interviews were geographically spread from Devon to the Scottish Highlands and lasted from forty minutes to almost two hours. The choice of venue is important and I had hoped to interview everyone in their own homes, feeling that they would be most relaxed there and it would be easier to control for background noise. On the whole this was successful and the participants, especially those living in the most distant areas, expressed appreciation that I had been prepared to travel to meet them. Two interviews were recorded in a university library, possibly because the participants did not know me and felt more confident to be met in a public place. One interview was moved to a local pub, because of noisy roadworks immediately outside the participant's home.

One interview was held at the RCSLT headquarters. I had hoped to conduct this interview at the participant's home. In our initial telephone conversation, however, the participant made it clear she did not want to do this, so we agreed to meet at the RCSLT London office. This entailed her taking a long rail journey followed by a bus or Tube across the city. The participant was one of the oldest, in her nineties, and my experience of people of a similar age meant that my preconceptions about her physical and sensory capacity led to my feeling an unfamiliar and unwelcome lack of control. I had booked a quiet, private ground-floor room, organised the furniture in order to facilitate recording and conversation, and allocated three hours in total. This had been more than enough for previous interviews and is suggested by other authors as a sufficient amount of time.[30] The participant, Sally (class of 1946), was almost an hour later than arranged, further raising my anxiety. However, when she eventually arrived, she gave no indication of care about time or distress. She appeared entirely confident in her abilities and immediately took charge, which disconcerted me, especially when she put me firmly in my place, as, having finally corrected the spelling of her name, I then managed to mispronounce it.

> *Interviewer:* This is Mrs. S […] K […] and I've got her spelling correct now and it's the twelfth of …
> *Sally:* The E-A-R of K is the E-A-R as in heart if you think about it.
> *Interviewer:* Yes of course.
> *Sally:* Not as in bear, fear, earn or any of the other possibilities. It's as in heart.

This metalinguistic exchange was a very typical speech therapy conversation, with attention being drawn to the mismatch between the spoken and written word. Happily the rest of the encounter went well, although I did need to leave for another appointment as soon as we concluded the interview, which again meant I felt somewhat gauche and impolite. For my own comfort, I would have much preferred to leave her in the safety of her own home.

The age of both narrator and researcher will impact upon the research process.[31] As noted above, a researcher's social expectations of older narrators and of their life experiences will influence the initial approach, as well as the interview and analysis process. Many narrators are older adults and many researchers are younger than their research participants. This indeed was my experience. The participants in this study were older than me and some had been at the top of the profession when I

was a junior, although now all were retired so had experienced changes, although not necessarily reduction, in status. Socially it is important to facilitate contributions, taking into account possible visual and hearing impairments and frailty, which to the best of my abilities I did. Where a narrator wore a hearing aid, I ensured I sat to the side of their good ear, so that they would hear me clearly. Where they were clearly frail, I ensured I followed their lead and paced the interview to enable them to contribute. I aimed to demonstrate an active listening stance and took care to develop narrators' responses in a number of ways, including non-verbal acknowledgement, single-word encouragement and response development. Memory can be a concern when interviewing the older population.[32] However, while some participants complained about having difficulties in recalling names and events, all were able to retrieve memories.

Age-related differing life-views can also impact both narrator and interviewer during the interaction and in the analysis and reporting stages, as indicated for example in Borland's work.[33] Several of the participants in this study stated very strongly held views with which they invited me to agree, for example Jill (class of 1952), discussing an issue which has exercised SLTs for years, suggested 'the name of the profession […] I mean we ought really have a totally different name. So I've come up with "Communicologist"'. I managed to hide my surprise at such times when opinions were expressed which contradicted my own opposite and equally strongly held views, and I did my best to accommodate an equity in discussion. At times this was a challenge for me because of the eminence of the participant (as with Jill); at others it was a challenge for the participant because of their extreme frailty.

Other surprises related to joining the profession. I had assumed that everyone had made a positive choice about this, but participants expressed a wide range of career considerations, including:

> *Jay (class of 1951):* I had thought about nursing, I had thought of being an almoner, and I had thought of being a physio, various things. I didn't want to be a teacher.
>
> *Janet (class of 1959):* What decided me? Not the most noble of reasons, […] you didn't get a grant to study something which was available in Aberdeen. Right? So, I explored what was not available in Aberdeen.

Despite the surprises (and there were many more), I hope that my personal subjectivity facilitated, rather than impeded conversation during the interviews. The transcripts and audio recordings provide evidence of the level to which I was able to achieve this.[34] What I am clear about is that the emotional baggage referred to by Abrams did not seem to be in evidence to any great extent and that intersubjective communication appeared to be successful.[35]

Building the stories

Analysis of an interview is disputed territory, with arguments about ownership of the narrative, co-construction and levels of privilege being claimed by authors from differing philosophical backgrounds.[36] Rather than impose my own privilege of a pre-conceived framework, I used thematic analysis to code and develop themes

inductively from the interview transcripts. This offers a transparent order of stages and replicability of the process, as well as visibility of the outcome of analysis.[37] It does, however, also reflect my original background in social science research, feeling the need to prove provenance and rigour throughout and thus remaining within my comfort zone. The coding went though many iterations, until the themes and subthemes emerged and I felt I had gained a coherent story from the narratives. The final global themes centred on participants' personal, professional and political stories.

In order to honour these stories, reporting took a life-story approach, both towards the participants and to the development of the profession. As such, I first considered the extent to which speech therapy was perceived as a female, class-based career and the ways in which participants navigated the social expectations of their times. Second, I addressed the working lives and career opportunities availed of by participants, looking at the changes in the client groups they met, their motivations for career and academic development, and their relationships with professionals both outside and inside the speech therapy field. Finally, I looked at the impact of the wider social and political environment on the profession and especially on the participants themselves.[38]

On a personal level, the initial impression from speaking to the participants was that they came from middle-class families. All stayed on at school well past the official leaving age of fifteen, which was in place from 1944 to 1972.[39] Five reported having attended boarding or fee-paying schools; others indicated that their head teachers had been involved in career direction, which suggested small classes and personal interest.[40] Several volunteered information about their parents' occupations (for example senior HMRC staff [Sally, class of 1946], senior education staff [Meg, class of 1950; Ursula, class of 1957, Jill, class of 1952], doctors) and social connections:

> *Selma (class of 1965):* Sandra's father and my father played golf together. And my father was a GP in [town]. And he heard that Sandra was doing speech therapy. And I didn't want to follow Dad into medicine.

Accents in particular all suggested middle-class backgrounds. Some of the English participants demonstrated Conservative Received Pronunciation (CRP), a characteristic today of older, upper-middle-class speakers, while all the others used a form of general RP, again suggesting this class background. The Scottish participants all used educated Scots-English. All was not, however, what it at first appeared and, as in the conversation with Sally referred to earlier, discussion about speech was explicit. Jess (class of 1957) reported, 'when I trained, you had to achieve an RP accent, because it was considered […] that was universal, universal BBC' and Millicent (class of 1956) said, 'They tried to iron out everybody's Scottish accent'. Althea (class of 1961), who self-identified as 'a working-class girl from Liverpool', but spoke in a CRP accent, the result of speech training, said of a colleague, 'she didn't really like me because she thought I was posh', while Sally (also CRP), once we had settled into a more comfortable conversation, was able to joke about her inability to work as a speech therapist in Scotland because of the local accent:

> [her child, on moving to Dumbarton from England said] 'Mummy will you tell me the language they're speaking, these people on the roof?' Who were mending the roof of the house we had bought. And I said 'darling I don't know what they're saying myself. I can't possibly tell you. And *they* [her emphasis] think they're speaking English'.

Speech therapy in the post-Second World War period was not well recognised (*Jay, class of 1951:* 'Who heard of speech therapy as a profession, never mind in 1948?'), but was perceived by the participants as comparable to other professions open to middle-class women at the time.

College interview experiences were similar across England and Scotland and across the entire period explored, with tests for general suitability for example:

> *Amanda (interviewed in 1951):* a psychologist who sat in the corner […] I had to hear a word and say it […] a nonsense word, And he sort of came alive at that point.

> *Abigail (interviewed in 1963):* I went for an interview and in those days, you went very nicely attired, wearing a hat, with my mother and a very close aunt in tow and of course, we got the inevitable IQ test and the personal interview and the good going over by [the Head of Department].

College included clinical experience and medical, educational, psychological and speech-based subjects:

> *Jess (speaking of studying in the mid 1950s):* Three times a week we had voice classes. We had movement classes. We had all sorts of training in presentation which stood me in good stead, because it taught me really how to present myself […] paediatric neurology […] anatomy […] Phonetics, lots of psychology.

> *Kathy (class of 1968):* it was very full-on. Never a minute to spare. In fact, I remember going to classes of an evening […] anatomy classes […] classes on a Saturday morning. And that was the normal development of speech and language in children. I can remember it to this day.

[Insert image 9 around here]

Meg, whose parents had made sure she did not train as an actress, expressed some amusement that 'one thing I came away with for my career as a speech therapist, a student, was an ability to diagnose syphilis', something, she reflected after the recording was turned off, that would not have pleased her parents had they known, despite it being a neurological symptom ('*not* the other end!' as she said).

Clientele included stroke survivors and those with cleft palate or stammering. The early focus on speech meant that therapy 'was all very articulation based really' (Carol, class of 1961), and it was only gradually that practice expanded. According to participants, 'language had not been invented' (Jay 1950s); 'linguistics had not been invented' (Carol, mid 1960s) and 'autism hadn't been invented' (Ursula, late 1960s).

New clinical groups emerged as participants gained experience: ‘babies with deafness’ (Jill, working in the 1950s); ‘voice disorders […] and if you've *heard* a free Presbyterian minister preaching’ (Selma, working in the1960s); ‘head injury […] I had a patient who had, a young man who had fallen off a roof and had a fractured skull […] his speech loss fascinated me’ (Abigail, working in the1970s). Participants also began to challenge the received wisdom of the times.

> *Janet (working in the 1970s):* Autism […] it was still the kind of ‘refrigerator mother’ attitude […] And I can remember thinking, ‘This family just don't fit this picture *at all*’ [her emphasis].

The appearance of linguistics in the late 1960s was a turning point: ‘the first hint I got of linguistics was when I did my taught Masters … and it was a complete mystery to me’ (Jess); ‘post-linguistics […] I think when linguistics came into the profession, it made a huge difference’ (Ruth; both speaking of the early 1970s). All agreed that linguistic theory redirected practice to aspects of language disorder previously not recognised. Then in the 1990s, SLTs began to work with swallowing difficulties, although it took some assertion to make things happen:

> *Thelma (class of 1956, but speaking of the early 1990s):* he was the director of the acute stroke unit. So I did go to him and say, we *have* [her emphasis] to do something about swallowing. So we did.

Participants all commented on the vast expansion in the range of identifiable clinical fields between 1945 (when the first participant qualified) and 2008 (when the last participant retired).

One of the most extraordinary and, to me, unexpected elements of the stories was the subjective modesty with which participants reported their achievements. Some were small or personal, such as that of Thelma above; others were of national professional or political importance:

> *Amanda (class of 1954):* to my surprise, was just before I retired, they gave me the Honours of College for just being an ordinary speech therapist.
>
> *Jill (class of 1952):* I was awarded an OBE in recognition of services to speech therapy. I recognise this was with the wonderful support of my colleagues […] the icing on the cake, an OBE.

But nevertheless across each of the transcripts, even with encouragement from myself as interviewer, the voices of these participants indicated only a quiet satisfaction with the direction in which their careers had taken them.

Given that oral history was originally focused on recording the voices of groups that had previously been ignored, the impact of feminist theory, challenging as it does the neutrality and objectivity claimed by traditional written histories, is unsurprising. Many feminist authors have explored the differing responses by and to women, depending upon the presentation of the conversational partner.[41] Gluck, for example, identifies relationships between the powerful and powerless (class, gender and privilege being elements of this); a female collaborative as opposed to confrontational ethos; and a

recognition of the importance of personal standpoint and social relations as being core to feminist theory, not least when women interview women.[42]

The participants in this study were all women aged between seventy and ninety-five at the time they were interviewed, and so all lived through the era of second-wave feminism as adults. From their interviews, however, this appeared if not to have passed them by, at least to have been tangential to their reported perceptions of their daily lives. Possibly this is because I did not introduce the issue directly in my interviews, something also noted by Gallway in her re-analysis of oral histories in the Millennium Memory Bank.[43] None of my participants engaged in a feminist framing of their careers, but they did all narrate stories of challenges met and agency exerted in overcoming those challenges, although they used a different explanatory model from the professional oppression adopted by many feminist authors.[44] Most accepted but negotiated ways around the social constraints of their times. In a shortage profession, they had working opportunities, which increased over the decades. Jay reported not working in the 1950s and embracing her new choice of status ('I was busy being married'), while for others:

> *Linda (1960s and 1970s):* there was always part-time work available and that was a tremendous help. I did all sorts of computations to fit in with family life.
>
> *Kathy (late 1970s and early 1980s):* [I was] encouraged to work a half day a week so I didn't have to leave.

The major social policy initiatives of the post-war Labour government, the subsequent liberalisation of education and equality legislation, and the resulting changing expectations of the balance between domestic and professional lives were more overtly indicated in the narratives of the participants and are recognisable in other largely female professions.[45] Many policies, notably the Quirk report which addressed speech therapy directly and had a long-term positive impact on the profession, were welcomed.[46] The first, and to date only, government report on speech, Quirk made recommendations which, being accepted by government, transformed the profession in both the short and the long term. These included recommendations on: speech therapy becoming a unified service under health as opposed to education; a move to all degree-level education; a quadrupling of staff numbers[47]; and a career structure.

> *Jay (class of 1951):* that Quirk Report, it was great. We had something we could actually refer to help us make our case […] [for] the number of therapists that we should have.

Participants were, however, vocal about perceived unfairness, with pay as a good example. Speech therapists were poorly paid in relation to education staff and particularly in relation to the medical staff with whom they worked. Attempts by governments of all colours to manage pay sometimes appeared to have the collusion of the male-led unions and there were frequent grading arguments.

> *Amanda (late 1980s):* the Department of Health had said they would hold up all the rest of the people getting their money if they argued the case for *us*. And so they [the union] just ditched us […] Totally outrageous.

> *Kathy (late 1990s):* I always loved my work. But the Agenda for Change experience just about finished me completely […] it was really bad because it put one therapist against another. It set one profession against another.

Introduced in 2004, Agenda for Change was, and is, the current NHS approach to managing pay for all non-medical staff.[48] It claims to rationalise terms and conditions of service, although at some considerable cost to the people attempting to make it happen. Possibly participants recognised that, as an female insider, I was familiar with the social conditions under which they conducted their personal and professional lives, so shared understanding was assumed: the rare speech therapy political campaigns over the period are still celebrated by the profession.[49] Certainly the narratives, with their focus on patients, career opportunities and policy influences on the profession, were what I had expected, so I hope this was not just my insider's failure to challenge and explore deeper political considerations.

A final ethical decision arose for me in reporting. How much detail should I include in the promised outline of the final study findings? I had not realised that being an insider could be such an uncomfortable position. A researcher can be keen to be rigorous, but anxious not to upset people. Being an insider means I have a longer-term commitment to SLT than an outsider researcher, and thus a need to maintain relationships over a protracted period. An unwillingness to offend may well constrain commitment to transparency with regard to the reported findings. Such over-protectiveness can be difficult to overcome, but the decision to send an abstract and a copy of the presentation to each participant appeared to be successful. Nine of the twenty participants replied, all with positive feedback, and there has been no criticism from any of the other participants. I hope they were happy with the outcome and think I captured the substance of the narratives.

Conclusion

Theoretical debates and controversies about the influence of subjectivity and intersubjectivity reflect the differing stages of oral history itself, not least when the researcher is an insider.[50] Feminist approaches to oral history investigations are well reported, with writers such as Jordanova asserting that the impact of the subjectivities of each partner in the interview, and resulting intersubjectivity, gives a different but equally valid historical truth from that of the traditional written form.[51] Others such as Gluck have explored personal feelings about the oral history process and its impact on themselves as researchers. Outlining her changed perspectives over a forty-year period, she believes that current feminist approaches continue to have a comfortable fit with the approaches used in oral history.[52]

This study is the first oral history of speech and language therapy in the UK. The experiences of participants (and myself as an insider researcher) must have been mediated during the construction of the oral history by their acknowledged and sometimes unquestioned personal characteristics (gender, status, class, generation and accent), roles, affiliations and experiences of each. At best, this can lead to a co-constructed narrative, facilitated and subsequently analysed by the researcher, developed through mutual respect and co-operation. At worst, it can lead to a breakdown in communication and abandonment of the interview, or even that part of

the project. Happily this did not occur. Abrams suggests that narrators have a 'critical subjectivity', which is the capacity to internalise, reflect upon and exert agency upon memory. This self-awareness, which enables the oral history process to proceed as smoothly as possible, is also essential in the researcher: to the best of my ability I attempted to achieve this.[53] My aim was to achieve Shopes' aspirations for oral history: to construct a story which was truthful to the narrators, while giving a theoretically grounded product which adds historical value.[54] Taking account of the subjectivity of the narrator, having a critical approach to one's own subjectivity as an interviewer and recognising the impact these have on intersubjectivity before, during and after the interview has taken place form the basis of sound oral history. I hope I have achieved this, despite much self-questioning along the way

The interviews took place with a group of women who were willing to share their opinions, but also shared a depth of self-knowledge and personal acceptance. Some of these interviews were with former senior professionals, some were with 'ordinary' speech therapists, neither powerless nor elite. The participants were women of their generation and class. They were all fully in control of their stories and subjectively placed themselves as people and professionals at the centre of the narratives. The elements each emphasised were those where they had been able to exert most agency. Their modesty was palpable. The conversations were easy and enjoyable. On reflection, I think, despite detours and changes in pace and conversational turn, they appeared to demonstrate meetings of equals, with genuine shared authority leading to co-constructed narratives emerging from our individual subjectivities and our intersubjective experience during the interview.

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NOTES

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Address for correspondence:
J.Stansfield@mmu.ac.uk